

We all fall down



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Plan D S A

Too many falls

Use of pressure alarms

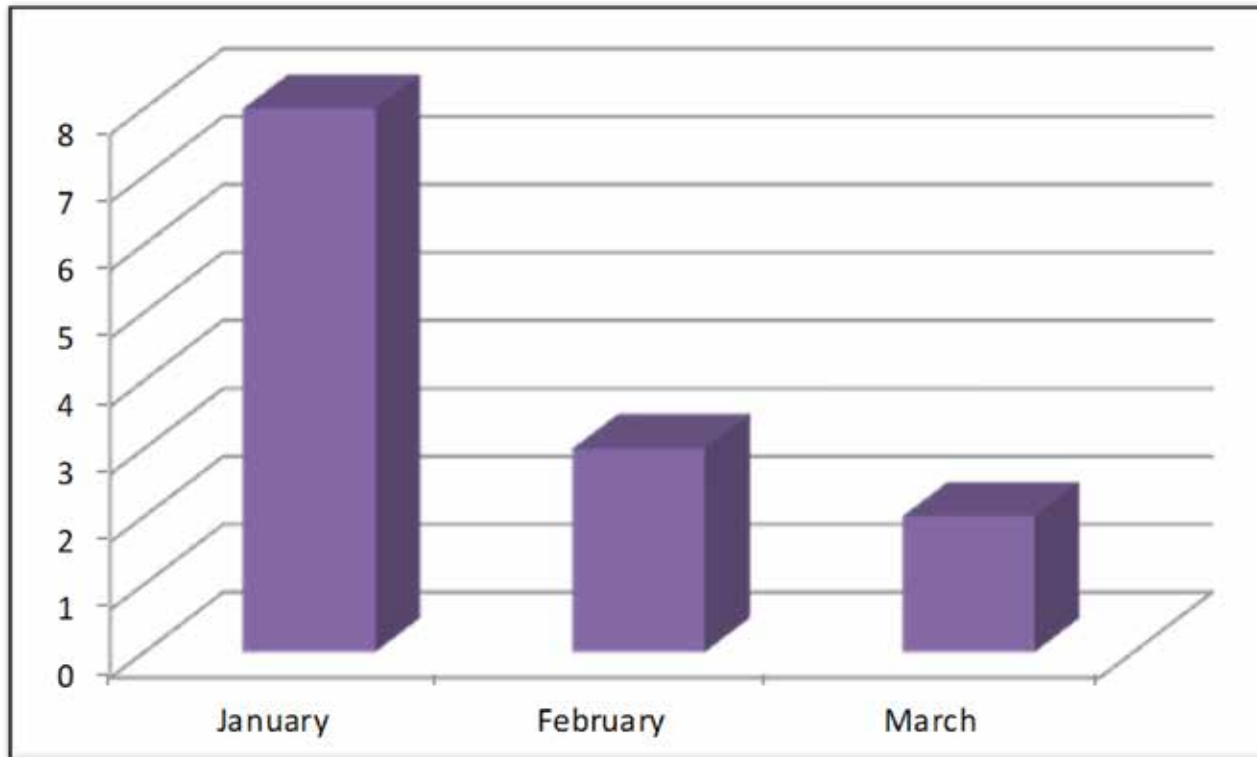
Baseline Data

- Reviewed number of falls since January, 2014
- Determined if and how falls were related:
 - Residents
 - Shifts
 - Time of day
 - Activities

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- Moved dining room tables so oxygen concentrators (cording) were against walls
- Process Improvement Team educated staff about Fall prevention
- Pressure alarms removed

First Quarter Results



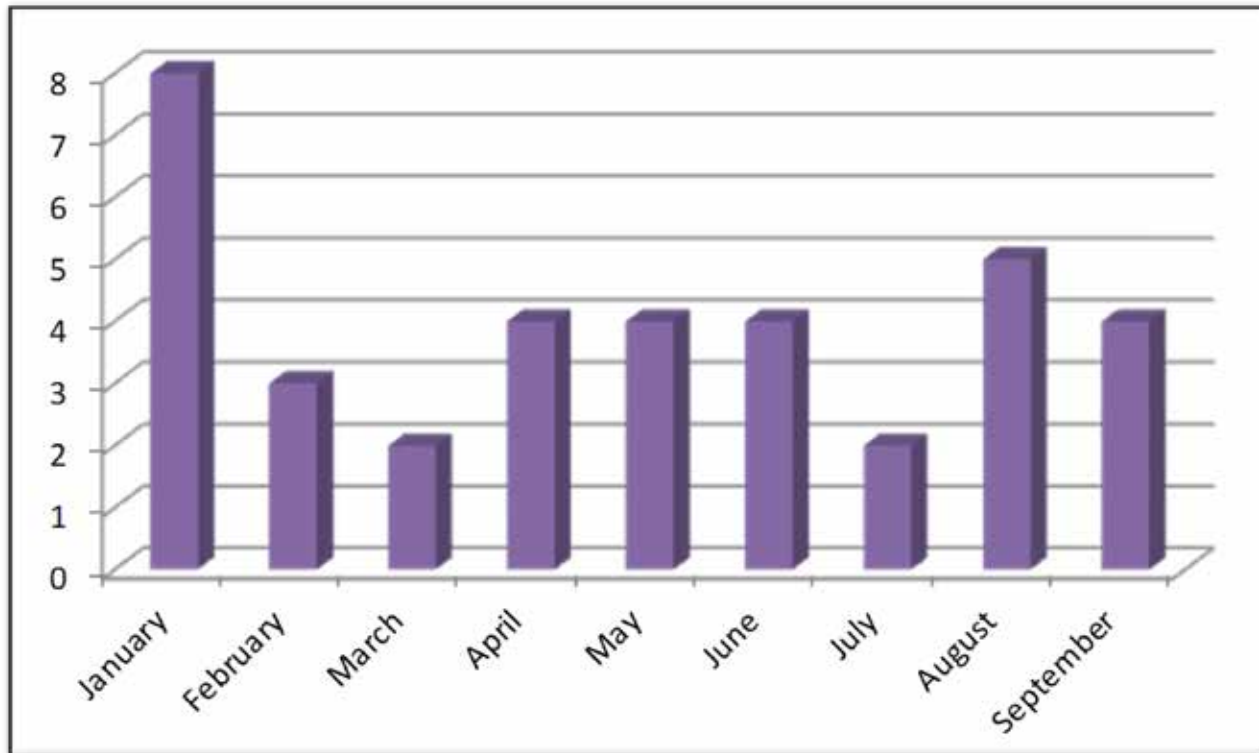
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- Trend – majority of falls occurred due to residents trying to self-toilet.
- Resident with repeat incidences was given education and an assistive device
- CareTracker messages to staff about importance of prompt toileting

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- During the cycle, it was determined that pressure alarms did not decrease the incidents of falls
- Mandatory inservice for all staff regarding fall prevention
- Results reported at quarterly Quality Assurance meeting
- Repeat as necessary

Results to date



Thank you